NON-PUBLIC?: N

ACCESSION #: 9512290261

LICENSEE EVENT REPORT (LER)

FACILITY NAME: Joseph M. Farley Nuclear Plant - Unit 2 PAGE: 1 OF 4

DOCKET NUMBER: 05000364

TITLE: Reactor Trip During DEH Card Change Out

EVENT DATE: 11/28/95 LER #: 95-008-00 REPORT DATE: 12/19/95

OTHER FACILITIES INVOLVED: DOCKET NO: 05000

OPERATING MODE: 1 POWER LEVEL: 100

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR

SECTION: 50.73(a)(2)(iv)

LICENSEE CONTACT FOR THIS LER:

NAME: R. D. Hill, General Manager - TELEPHONE: (334) 899-5156

Nuclear Plant

COMPONENT FAILURE DESCRIPTION:

CAUSE: B SYSTEM: JJ COMPONENT: DCC MANUFACTURER: W120

REPORTABLE NPRDS: YES

SUPPLEMENTAL REPORT EXPECTED:

ABSTRACT:

At 1233, on November 28, 1995, with Unit 2 in mode 1 operating at 100 percent power, the reactor tripped due to a turbine trip in response to a loss of digital electro-hydraulic control (DEHC) overspeed protection circuitry. Investigations indicated the turbine trip was caused by the loss of the primary overspeed protection controller (OPC) (DROP 52) while the backup OPC (DROP 2) was momentarily shutdown for card replacement. An electronic card was being inserted in the I/O (Input/Output) chassis to repair DROP 2. A design defect, associated with card replacement in the control circuitry, allowed a momentary interrupt condition to exist on the 110 bus at the time of the replacement card insertion. This interrupt condition caused the operating digital processing unit (DROP 52) to stop processing I/O data. DROP 52 attempted to transfer OPC control to DROP 2 which was momentarily shutdown for card replacement. This resulted in a turbine trip due to a momentary loss of both OPCs.

This event was caused by the presence of a latent design defect in the DEHC circuitry which did not provide for the bumpless transfer during card change out. Three cards, with the latest hardware revision correcting the design defect, were replaced on Unit 2. An additional two cards in the Input/Output (I/O) chassis shared by DROP 52 and DROP 2, associated with the original fault conditions on DROP 2, have been replaced. Applicable Unit 1 DEHC cards will be replaced when plant conditions permit. A review of the DEHC card upgrade history for all DEHC cards is in process to determine if other hardware revisions are required.

END OF ABSTRACT

TEXT PAGE 2 OF 4

Plant and System Identification

Westinghouse -- Pressurized Water Reactor Energy Industry Identification System codes are identified in the text as XX!.

Description of Event

At 1233, on November 28, 1995, with Unit 2 in mode 1 operating at 100 percent power, the reactor tripped due to a turbine trip in response to a loss of digital electro-hydraulic control (DEHC) overspeed protection JJ!. Investigations indicated the turbine trip was caused by the loss of the primary overspeed protection controller (OPC) (DROP 52) while the backup OPC (DROP 2) was momentarily shutdown for card replacement. As an electronic card was being inserted in the Input/Output (I/O) chassis to repair DROP 2, a design defect, associated with card replacement in the control circuitry, allowed a momentary interrupt condition to exist on the I/O bus at the time of the replacement card insertion. This interrupt condition caused the operating digital processing unit (DROP 52) to stop processing I/O data. DROP 52 attempted to transfer OPC control to DROP 2, which was momentarily shutdown for card replacement. This resulted in a turbine trip due to a loss of both OPCs.

On November 26, 1995, an alarm was received in the control room which indicated that DROP 2 had a fault. Due to the fault condition on DROP 2, the OPC control was automatically transferred to DROP 52. An investigation by the DEHC vendor and plant personnel determined that two cards of different types were suspect. The DEHC representative indicated that both of these cards could be changed out while the unit was on-line. One card in DROP 2 was replaced on November 27, 1995, with no problems encountered, and DROP 2 was returned to service in the backup mode. The

card that was removed was placed in a DEHC simulator and monitored. Since no problem was identified with the removed card tested on the simulator, the following day, it was decided that the remaining suspect card should be replaced. On November 28, 1995, the remaining suspect card which shared communication between DROP 52 and DROP 2 was removed. As expected, only DROP 2 was affected by the removal of this card. In the process of inserting the replacement card, DROP 52 attempted to transfer OPC control to DROP 2 due to the momentary voltage transient. The plant technician noted the transfer and attempted to reset DROP 52 but could not reset DROP 52 prior to a turbine trip due to a loss of both OPCs for greater than 4 seconds. Subsequent to this event, an investigation by the DEHC vendor revealed that this same problem had occurred in 1989 on other customers' units and had been corrected by a design change to printed circuit cards. Farley Nuclear Plant was not informed of this change under Vendor Technical Information Program or the turbine generator business team correspondence.

TEXT PAGE 3 OF 4

Cause of Event

A root cause investigation determined that this event was caused by the presence of a latent design defect in the DEHC circuitry which did not provide for the bumpless transfer during card change out.

Safety Assessment

The health and safety of the public was unaffected by this condition.

This event is reportable because of the actuation of the reactor protection system.

All systems operated as designed with the exception of NI-36 which had been declared inoperable due to reading lower than expected prior to the trip. Following the reactor trip, the NI-36 detector was replaced.

This event would not have been more severe if it had occurred under different operating conditions.

Corrective Action

Three cards, with the latest hardware revision, correcting the design defect were replaced on Unit 2. Two additional cards associated with the original fault conditions on DROP 2 have been r placed on DROP 52 and on DROP 2.

Unit 1 cards will be replaced at the next outage of sufficient duration.

The DEHC card inventory has been submitted to the DEHC vendor and a review of the card upgrade history for all DEHC cards is in process to determine if other hardware upgrades are required.

FNP has discussed with the vendor the need for accuracy in response to questions regarding technical issues associated with the DEHC.

TEXT PAGE 4 OF 4

Additional Information

The turbine's mechanical overspeed trip device was operable during this event.

The following LER's involved reactor trips associated with DEHC system failures.

LER 95-001-00 (Unit 1) - Reactor Trip Due To A Loss of Turbine DEHC Overspeed Protection

LER 94-004-00 (Unit 2) - Reactor Trip Due To A Loss of Turbine DEHC Overspeed Protection

LER 94-003-00 (Unit 2) - Reactor Trip Due To Turbine Control System Intermittent Failure

LER 91-010-00 (Unit 1) - Manual Reactor Trip Due To Governor Valve Closure Caused By A Degraded DC Voltage
Output From The Primary Operator Auto
Controller Power Supply In The Main Turbine
DEHC System And A Failure Of The Circuitry
Which Should Have Transferred The Power
Supply

LER 89-015-00 (Unit 2) - Reactor Trip Caused By A Voltage Transient On The DEHC Inverter

ATTACHMENT TO 9512290261 PAGE 1 OF 1

Southern Nuclear Operating Company Post Office Box 1295 Birmingham, Alabama 35201 Telephone (205) 868-5131 Dave Morey Southern Nuclear Operating Company Vice President Farley Project the southern electric system

December 19, 1995

Docket No.: 50-364 10 CFR 50.73

U. S. Nuclear Regulatory Commission ATTN: Document Control Desk Washington, D.C. 20555

Joseph M. Farley Nuclear Plant - Unit 2 Licensee Event Report No. 95-008-00 Reactor Trip During DEH Card Change Out

Ladies and Gentlemen:

Joseph M. Farley Nuclear Plant - Unit 2 Licensee Event Report No. 95-008-00 is being submitted in accordance with 10 CFR 50.73(a)(2)(iv). If you have any questions, please advise.

Respectfully submitted,

Dave Morey

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Enclosure

cc: Mr. S. D. Ebneter, Region II Administrator Mr. B. L. Siegel, NRR Senior Project Manager Mr. T. M. Ross, FNP Resident Inspector

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